



OFFICE OF COMBATIVE SPORTS

PHYSICAL AND NEUROLOGICAL EXAMINATION

Only a licensed medical doctor or physician's assistant may conduct this examination and complete this form. The exam must be completed in person, as exams administered virtually are not accepted.

APPLICANT INFORMATION

Last name First name Middle name Date of birth

PHYSICAL INFORMATION Your physician must complete the remainder of this form in its entirety.

Height: Weight: Temp: Afebrile RR: BP: HR:
Normal Abnormal Normal Abnormal

General HEENT Vision Heart Chest
Abd. Ext. Skin Neuro. Other:

Abnormalities:

Based on your personal observation and review of the exam results, is it your medical opinion that this individual is physically fit to be licensed and compete in combative sports? YES NO

If no, please explain:

Physician's name Signature License number Date

Email Phone Clinic/Hospital